Flexible Spending Account Plans

2010

- Health Care
- Dependent Care

City of Seattle

City of Seattle

Flexible Spending Account Plans

The City of Seattle Flexible Spending Account (FSA) Plans allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you do not pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

The City of Seattle offers two types of FSA Plans:

- **Health Care FSA** allows you to set aside pretax dollars to pay for certain expenses not covered by your health plans (for example, the cost of orthodontia not fully paid by your dental plan and copays for office visits).

- **Dependent Care FSA** allows you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

This guide explains how Health Care and Dependent Care FSAs work. If you decide to enroll, you must complete your online enrollment, or return the enrollment form to your HR representative:

- Within 31 days of becoming a City employee.
- Within 31 days of a qualifying change in family status.
- During the open enrollment period if you wish to enroll or re-enroll for next year.

For additional information go to the City of Seattle web site at http://personnelweb.ci.seattle.wa.us/benefits/home.aspx, or contact your department human resource representative.

You must re-enroll each year at open enrollment to continue participating in FSAs.

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HOW FSAs WORK

Here's how:

- You decide how much you want to contribute to the Health Care and/or Dependent Care Flexible Spending Account.

- You enroll by completing the enrollment form. By completing the form, you are authorizing the City of Seattle to deduct a certain portion of your salary each pay period on a pretax basis. These contributions are then placed into your account(s) throughout the calendar/plan year via payroll deduction. Benefit Administration Company administers the accounts for the City of Seattle.

- As you incur eligible expenses, you submit reimbursement request forms – plus receipts and/or other documentation - to Benefit Administration Company. **Requests for reimbursement must be received by 5 p.m. the Thursday before.** Direct deposits will usually be posted to your account the following Thursday or Friday, depending on the financial institution, and checks mailed to your home should arrive Saturday or the following Monday. Unforeseen circumstances may delay receipt of reimbursements. Requests may be mailed or faxed to:

  Benefit Administration Company, LLC
  PO Box 550
  Seattle, WA 98111-0550
  206-625-1800 ext 307
  800-967-3709 ext 307
  Fax 206-682-8016

- You may submit reimbursement requests for expenses incurred during the plan year any time through March 31 of the following year (requests must be received by Benefit Administration Company no later than March 31), and you may submit multiple bills or receipts with one reimbursement request form.

- Each year during open enrollment, you must re-enroll to continue participating and you may change the amount you contribute.

GENERAL RESTRICTIONS

Because of the tax advantages available to you, the IRS limits how you can use the FSA and how much you can contribute:

- Under the City plan, the maximum that can be contributed to the Health Care FSA is $5,000.00 per year. The maximum amount that can be contributed to the Dependent Care FSA is $5,000.00 per year if married filing a joint return or head-of-household; $2,500.00 if married filing separately.

- The minimum that can be contributed to either FSA is $300.00 annually.

- Health Care and Dependent Care FSA are separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.

- Due to a qualifying status change, you may terminate your participation during the Plan year. However, expenses you incur after your termination date will not be eligible for reimbursement even if you still have an account balance remaining.

- Expenses for certain eligible services incurred during the plan year are reimbursed from an FSA. You have until March 31 of the following year to file reimbursement requests (your request must be received by Benefit Administration Company no later than March 31).

- You must use the FSA money or you lose it. **Any money left in your FSA account that cannot be reimbursed is forfeited**, so it is important to estimate annual expenses carefully before enrolling and set aside only as much as you expect to spend.

- You cannot use a Health Care FSA to pay expenses you also claim as health care deductions on your income tax return.

FSA contributions may affect Social Security benefits. Because you and the City do not pay Social Security (FICA) taxes on the money you contribute, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained through participation in an FSA outweigh any loss in benefits. Contact your tax advisor for help deciding whether or not a FSA is right for you.

Nondiscrimination testing may affect your contributions. Nondiscrimination testing is conducted to ensure that the plan does not favor highly compensated employees. If the City fails nondiscrimination testing, highly compensated employees may be asked to limit or stop their contributions to the program.

HOW YOU CAN ENROLL

There are two ways you can enroll into the FSA plans:

Via the Employee Self-Service module available from any City computer

By filling out the enclosed FSA enrollment form, and returning it to your Department's Human Resources Representative.

To complete your enrollment online:

Log onto the InWeb

1. **Go to**: http://selfservice.ci.seattle.wa.us/.
2. **Select** Employee Self-Service/.
3. **Enter your employee number and password** (if you do not know your employee number, contact your HR rep. For a password reset contact DoIT or the appropriate department contact.)
4. **Select Open Enrollment** on the menu, left side of the screen, under FAMILY.
5. **Select Flexible Spending Account.** If this is your first time opening the benefits enrollment, review the agreement and select agree.

6. **Select Flexible Spending Account** (again).
   Step 1 - Select re-enroll *or* enroll.
   Step 2 - Enter *MONTHLY* amount.
   Step 3 - Save your changes.
7. **Select** Summary of Election to confirm your 2010 benefit elections.

If you want to receive direct deposit for your reimbursements, please submit the enclosed Authorization Agreement for Direct Deposit Form once you've enrolled. If you are already receiving direct deposits from Benefit Administration Company, you do not need to complete another form.

The Personnel Department, Benefits Unit verifies your eligibility and transmits enrollment information to Benefit Administration Company, City of Seattle's FSA plan administrator.

FUTURE OF THE FSA PLANS

The City of Seattle has established the Flexible Spending Account Plans with the intention that it will be maintained indefinitely; however, the City reserves the right to alter, amend, delete, cancel, or otherwise change the plans or any of the provisions of the plans at anytime.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you are a regularly appointed full-time or part-time employee and have eligible health care expenses, including medical, dental and vision, you are eligible to participate. Expenses for your eligible dependents are also covered by the plan, including domestic partner if you claim him or her as your IRS tax dependent.

HEALTH CARE FSA vs. ITEMIZED TAX DEDUCTION

You may use a Health Care FSA to pay for any health care expenses considered tax deductible by the IRS, but you also have the option of taking a federal income tax deduction for health care expenses if your eligible expenses exceed 7.5% of your adjusted gross income (AGI). Your contributions to the Health Care FSA do not count toward reaching the 7.5% AGI threshold. In other words, you may not take a tax deduction for the same expenses that are reimbursed from a Health Care FSA. For most people, the Health Care FSA makes the most sense and offers you significant income tax savings throughout the calendar year. Please see a tax advisor for advice on your personal situation.

SAVINGS EXAMPLE

The following example shows how the Health Care FSA can provide a tax advantage and is based on 2006 tax rates. If the rates change, the example could be affected.

The example is for illustration only and is not intended to show the actual effect on your taxes. Each individual's tax situation is different and you should discuss your situation with your personal tax advisor.

When you decide whether to participate in the Plan, you should consider your expected income and health care expenses for 2009, the possibility of changes in those amounts, and the "use it or lose it" rule as explained on page 7. Also, consider whether you will use the standard deduction or itemize your deductions. The example is based on the standard deductions.

Example:
Cynthia is a single person. Her job with the City pays an annual salary of $47,000. Her health care expenses average $275 per month. She finds that her savings in income taxes will be $1,057 greater with the Health Care FSA.

This example is based on 2006 tax rates and assumes that Cynthia has no additional income, files as single, takes the standard deduction, and claims one personal exemption.

	Without FSA	**With FSA**
Salary	$ 47,000	$ 47,000
FSA Contribution	$0	-$3,300
Adjusted Gross Income	$ 47,000	$ 43,700
Standard Deduction	-$ 5,150	- $5,150
Personal Exemption	- $ 3,300	-$ 3,300
Taxable Income	$ 38,550	$ 35,250
Income Tax Before Credits	$ 6,175	$5,370
Income Tax Savings on FSA Contributions	$0	$805
FICA Savings on FSA Contributions	$0	$252
Total Tax Savings	$0	$1,057

Tax savings are $1,057 greater with Health Care FSA.

ELIGIBLE HEALTH CARE EXPENSES

Following is a partial list of health care expenses eligible for reimbursement through the Health Care FSA. If you have questions about expenses not listed, contact Benefit Administration Company at 800-967-3709 ext 307.

- Acupuncture
- Allergy Medicine*
- Ambulance
- Antacids*
- Artificial Limbs
- Athletes foot medicine*
- Birth control pills
- Braille books and magazines
- Car controls for a disabled person
- Care for a mentally disabled child in a special home
- Chiropractor fees
- Christian Science practitioner fees
- Coinsurance/copayments
- Cold/sinus medicines*
- Contact lenses and contact cleaning solutions
- Cough syrup*
- Crutches
- Deductibles for medical, dental and vision plans
- Dental fees
- Dentures
- Diagnostic fees
- Dietary Supplements**
- Drug addiction treatment
- Eyeglasses
- Eye exams
- Fertility enhancement
- Hearing aids and batteries
- Hemorrhoid medicine*
- Home improvements for medical reasons
- Hospital bills
- Hypnosis for treatment of an illness
- Insulin
- Laboratory fees
- Laser eye surgery
- Laxatives*
- Learning disability tuition and tutoring fees for child when prescribed by a physician
- Maternity care
- Medical conferences
- Medical ointments (Neosporin)*
- Medicated Shampoo**
- Mileage related specifically to medical condition
- Mouthwash**
- Naturopathic provider fees
- Nicotine patches and gum*
- Nutritional Supplements**
- Obstetrical services
- Operations
- Optometrist
- Orthodontics
- Orthopedic shoes
- Oxygen
- Pain relievers (aspirin, Tylenol)*
- Physician fees
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Routine physicals
- Seeing-eye dog and its upkeep
- Skilled nurse fees (including board and Social Security taxes you pay)
- Smoking cessation programs prescribed drugs
- Sore muscle medicines (Ben Gay)*
- Spa/pool equipment prescribed by physician and allowed by the IRS
- Special schools for mentally impaired or physically disabled person
- Telephone designed for hearing impaired person
- Television audio display equipment for hearing impaired person
- Therapeutic care for drug and alcohol addiction
- Therapy received as medical treatment
- Transportation expenses for medical purposes
- Tuition at special school for disabled person
- Tuition portion that goes for medical care
- Vaccines
- Vitamin Supplements**
- Well-baby and well-child care Wheelchair
- Wigs required for medical purposes
- X-rays

* Required Documentation: A store receipt showing the place of purchase is required and must include the date of purchase, name of the item and the amount charged.
**Required Documentation: A letter of medical necessity from our physician or dentist

INELIGIBLE HEALTH CARE EXPENSES

Following is a partial list of health care expenses not eligible for reimbursement through the Health Care FSA. If you have questions about expenses not listed, contact Benefit Administration Company at 800-967-3709 ext 307.

- Cosmetic surgery or procedures of any kind
- Deodorant
- Diaper services
- Divorce expenses (even if recommended by a physician)
- Domestic help fees (for services of a non-medical nature)
- Facial creams
- General counseling (e.g. family, marital or couple)
- Health club memberships if unrelated to medical condition
- Health insurance premiums
- Insect repellant
- Lens replacement insurance
- Long term care expenses
- Long term care insurance premiums
- Maternity clothes
- Physical therapy treatments for general well-being
- Sunscreen
- Toothpaste
- Union dues
- Vitamins taken for general health

ESTIMATING EXPENSES

The following worksheet can help you estimate your eligible health care expenses not covered by your other benefits. Remember, all eligible expenses for you, your spouse, and your eligible dependents are reimbursable from your Health Care FSA.

Medical Expenses	Estimated Plan Year Expenses
Copayments	$_____
Deductibles	$_____
Physical Exams	$_____
Prescription Drugs	$_____
Surgical Fees	$_____
X-Ray or Lab Fees	$_____
Other Medical Expenses	$_____

Vision Expenses	Estimated Plan Year Expenses
Contact Lens Supplies	$_____
Copayments	$_____
Deductibles	$_____
Eye Examinations	$_____
Laser Eye Surgery	$_____
Prescription Contact Lenses	$_____
Prescription Eyeglasses or Sunglasses	$_____

Dental Expenses	
Copayments	$_____
Deductibles	$_____
Dentures	$_____
Examinations	$_____
Orthodontia	$_____
Restorative Work (crowns, caps, bridges)	$_____
Teeth Cleaning	$_____
Other Dental Expenses	$_____
Total Column 1	$_____

Other Expenses	
Acupuncture, chiropractors, naturopaths (needs verification)	$_____
Hearing Aids	$_____
Immunization Fees	$_____
Psychiatrist, Psychologist Counseling *	$_____
Total Column 2	$_____

Total Column 1 $ _____ + Total Column 2 $ _____ = Total Estimated Expenses $_____

* Allowed for treatment of specific physical or mental disorder (e.g. depression, alcohol, or drug treatment). A physician's diagnosis is necessary for reimbursement.

MAKING CHANGES

The election you make when you enroll is effective for the entire plan year. You may only change your election – begin, increase, decrease or stop your contributions – during open enrollment, or when you have a qualifying status change. The following are examples of qualifying status changes:

- Change in your legal marital status including marriage, divorce, and death of a spouse, legal separation, or annulment.
- Change in the number of your dependents due to birth, adoption, or placement for adoption, or death of a dependent.
- Ending or starting employment by you, your spouse or dependent, including a switch between part-time and full-time status, a strike, lockout or beginning or return from an unpaid leave of absence (including FMLA leave).
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan.
- Change in the place of residence or work of you, your spouse, or dependent.
- Significant changes in the health coverage of the employee or spouse attributable to the spouse's employment.

You have 31 days from the date of the event to change your FSA election(s). The change you make must be consistent with and on account of your status change. For example, if you adopt a child you can begin or increase contributions to a Health Care FSA (that is consistent with the status change), but you cannot stop or reduce contributions to a current Health Care FSA (that is not consistent). Questions? Please contact your department human resources representative.

REIMBURSEMENT

Copy and use the Health Care Reimbursement Request Form at the end of this booklet to get reimbursed for health care expenses or use the copy on the Benefits web site at http://inweb/personnel/benefits

DEBIT CARD OPTION

The health care flexible spending account debit card, the Benny Card, enables you to pay for eligible flexible spending account expenses directly from your health care flexible spending account so you don't have to wait for reimbursement though receipt submittal is still required.

The debit card pays for non-reimbursed out-of-pocket expenses for medical, dental, prescription drug, vision and hearing services and supplies at any merchant who accepts VISA such as doctor's offices, dental and vision clinics, hospitals, pharmacies, mail order pharmacy programs, and drug stores.

You may request the debit card by calling Benefits Administration Company at 206-625-1800, extension 307 or emailing flexcs@baclink.com. An email address is required for notifying you when receipts are required to be submitted. Please allow 8 – 10 business days to receive your card(s) in the mail.

You may continue to submit your itemized receipts and reimbursement form, as you do now, to Benefit Administration Company for reimbursement by check or direct deposit.

FILING A CLAIM

Claims for reimbursement from your spending accounts may be submitted any time during the plan year in which the expenses are incurred, but must be submitted before March 31st following the close of the plan year. With the claim form, you must submit a bill or receipt from the provider that gives the following information:

- Name and address of the provider and – in some cases – the provider's taxpayer identification number and signature
- The date(s) services were provided
- The type of service provided
- Who received the service
- Amount you are responsible to pay

When your Health Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year. Even if your reimbursement request is greater than your current account balance, you will be reimbursed for the total amount of your request, up to the total Health Care FSA contribution you elected for the plan year.

NOTIFICATION OF CLAIM DENIAL

You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an additional 90 days. If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied.

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, a description of any additional information or material needed to complete your claim, an explanation of why the information is necessary and appropriate information about the plan's claims review procedures.

APPEALING A DENIED CLAIM

If your claim is denied and you wish to appeal, you must file your appeal with the Plan Administrator (Benefit Administration Company) within 60 days after you receive the denial. Your appeal should include any additional information that you wish the Plan Administrator

to consider. If your appeal is not filed within this 60-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. The decision will be final and binding on all parties and will be communicated to you in writing. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

IF YOU LEAVE EMPLOYMENT

If you leave employment you may continue participating in your Health Care FSA (contributing to the account and requesting reimbursements) through the end of the calendar year as long as you elect to continue medical coverage under COBRA. You have until March 31 of the following year to submit reimbursement requests for expenses incurred during the calendar year while under COBRA.

If you leave employment and do not continue your Health Care FSA under COBRA, your participation in your FSA ends the day you leave employment. You have until March 31 of the following year to submit reimbursement requests for expenses incurred through the date you leave.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you are a regularly appointed full-time or part-time employee and have children (including adopted children, step children, and foster children) under age 13 who qualify as dependents on your federal income tax return; a spouse who is physically or mentally incapable of self-care; or any other person who qualifies as a dependent on your federal income tax return if that person is physically or mentally incapable of self-care, you are eligible to participate.

To qualify as a dependent for federal income tax purposes, an individual generally must be a member of the taxpayer's household, receive more than one-half of his or her total support from the taxpayer, and fall within the class of persons described in Section 152 of the Internal Revenue Code. Children of divorced or separated parents may qualify as tax dependents of the parent who has custody for the greater part of the calendar year. IRS Publication 503, Child and Dependent Care Expenses, contains additional information regarding qualifying persons.

DEPENDENT CARE FSA vs. TAX CREDIT

If you will pay dependent care expenses in 2010, you have two options to save money on taxes:

- Dependent Care FSA – reduces the amount of pay subject to federal income and Social Security taxes.
- Child and Dependent Care Tax Credit – reduces the amount of federal income tax you pay.

The information provided below will assist you in deciding between the Dependent Care FSA and the Child and Dependent Care Tax Credit.

- As your adjusted gross income increases, the tax credit goes down while your federal income and Social Security taxes go up.
- The tax credit allows you to claim only up to $3,000.00 in eligible expenses for one dependent and up to $6,000.00 for two or more dependents.
- Generally, the Dependent Care FSA allows you to contribute up to $5,000.00 regardless of the number of dependents.
- You cannot use the Child and Dependent Care Tax Credit on your tax return for expenses that are reimbursed through Dependent Care FSA; the tax credit is reduced dollar for dollar by the amount you are reimbursed through the Dependent Care FSA.
- If you are married and will be filing a separate return for 2009, but not as head of household, you are ineligible for the Child and Dependent Care Tax Credit. Therefore, the Dependent Care FSA may be the only tax benefit available to you

for dependent care expenses. A maximum annual contribution of $2,500.00 would apply to you in this case.

The size of your tax savings will depend upon several factors, including your income, spouse's income, child's age, amount of dependent care expenses, filing status, and number of personal exemptions.'

Since tax laws are complicated and subject to change, you should re-examine your tax situation every year and consider discussing your situation with a tax specialist. You may need to report on your tax return form 2441 how much was withheld for daycare and who you paid.

SAVINGS EXAMPLES

The following examples show how the DCAP can provide a tax advantage and are based on 2006 tax rates. As the rates change, the examples will be affected.

These examples are for illustration only and are not intended to show the actual effect on your taxes. Each individual's tax situation is different and you should discuss your situation with your personal tax advisor.

When you decide whether to participate in the plan, you should consider your expected income and dependent care expense for the plan year, the possibility of changes in those amounts, and the "use it or lose it" rule as explained on Page 7. Also, consider whether you will use the standard deduction or itemize your deductions. The examples are based on the standard deduction.

EXAMPLE #1:
Karen is a single parent with one child in daycare during 2009. Her job with the City pays an annual salary of $44,000. Her childcare expenses average $300 per month. She finds that her savings will be $215.40 greater with the DCAP than with the tax credit.

This example is based on 2006 tax rates and assumes that Karen has no additional income, files as head of household, takes the standard deduction, and claims two personal exemptions. This example is for illustration only and is not intended to indicate the actual effect on your taxes. Each individual's tax situation is different and you should evaluate your own situation with your personal tax advisor.

	Without DCAP	**With DCAP**
Salary	$ 44,000	$ 44,000
DCAP Contribution	$0	-$3,600
Adjusted Gross Income	$ 44,000	$ 40,400
Standard Deduction	-$ 7,550	- $7,550
Personal Exemption	- $ 6,600	-$ 6,600
Taxable Income	$ 29,850	$ 26,250
Income Tax Before Credits	$ 3,940	$3,400
Income Tax Savings on DCAP Contributions	$0	$540
FICA Savings on DCAP Contributions	$0	$275.40
Total Tax Savings	$0	$815.40
Dependent Care Tax Credit	$600	$0
Total Tax Savings	$600	$815.40

DCAP Tax savings are $215.40 greater for this situation than the tax credit.

EXAMPLE #2:
Steve is married and has one child. Steve and his spouse earn a combined income of $91,000 per year. They pay $6,200 per year for their daughter's day care. Their tax savings will be $1,032.50 greater with the DCAP than with the tax credit.

This example is based on 2006 tax rates and assumes that Steve and his spouse have no additional income, file a joint return, take the standard deduction, and claim three personal exemptions.

	Without DCAP	**With DCAP**
Salary	$ 91,000	$ 91,000
DCAP Contribution	$0	-$5,000
Adjusted Gross Income	$ 91,000	$ 86,000
Standard Deduction	-$10,300	-$10,300
Personal Exemption	- $ 9,900	-$ 9,900
Taxable Income	$ 70,800	$ 65,800
Income Tax Before Credits	$ 10,815	$9,565
Income Tax Savings on DCAP Contributions	$0	$1,250
FICA Savings on DCAP Contributions	$0	$382.50
Total Tax Savings	$0	$1632.50
Dependent Care Tax Credit	$600	$0
Total Tax Savings	$600	$1632.50

DCAP Tax savings are $1,032.50 greater for this situation than the tax credit.

ELIGIBLE EXPENSES

In general, you can use the plan to pay dependent care expenses for an eligible dependent so that you can work. Here are more detailed guidelines:

- Your dependent care expenses must be employment-related. For instance, you may use the plan to pay for childcare expenses while you work, but you may not use the plan to pay for a caretaker while you go to a movie.

- Eligible expenses include charges for care of an eligible dependent inside or outside of your home, including such things as feeding, administration of medicine, general supervision, and nursery school. (Charges may include household services such as cooking, cleaning, and general housekeeping if they are incidental to care for a qualifying person.)

- Dependent care services may be provided inside your home, in a licensed day care shelter, or in someone else's home.

- For dependents other than your children under age 13, services provided outside your home are reimbursable only if the dependent spends at least eight (8) hours each day in your home.

- Out-of-home care expense must comply with all applicable state and local regulations if the facility provides care for more than six nonresident individuals. (State and local licensing laws may require licensing where care is provided for fewer persons.)

- Services must occur during the plan year (January 1 through December 31), and must be provided while you are employed. If you are married, they must also be provided while your spouse is employed (or if your spouse is a full-time student, while your spouse attends school).

INELIGIBLE EXPENSES

Some dependent care expenses do not qualify for payment through the plan, as follows:

- The cost of schooling for a child in the first grade or above;

- The cost of kindergarten if the cost of schooling can be separated from the cost of before or after school care;

- Camp expenses when the child stays overnight;

- Itemized expenses for classes such as dance, gym, swimming, language, etc. If the fee for the class is included in the regular weekly or monthly fee, then the expense is allowable according to the IRS regulations;

- Payments to a person for whom you can claim a dependency exemption for federal income tax purposes;

- Expenses which have been paid from other sources, such as another employer's plan;

- Expenses you pay during the months your spouse has no income. If your spouse is a full-time student or totally disabled, however, special rules apply. These rules are explained under "Estimating Expenses".

- Expenses you pay if you are absent from work due to illness or injury, even if you receive sick pay and continue to be considered an employee, or while on vacation, holiday, or other time off.

For more information about eligible or ineligible expenses, please refer to the tax instructions for filing Federal Income Tax Form 1040 and IRS Publication 503, Child and Dependent Care Expenses.

ESTIMATING EXPENSES

To participate in the Dependent Care Assistance Plan, you must first estimate the amount of eligible dependent care expenses you expect to incur during the plan year and then calculate your annual salary reduction amount. Your annual salary reduction amount is subject to the following limitations.

- If you are unmarried, the amount of your salary you may contribute to the plan is the lesser of $5,000 or your earned income.

- If you are married, the amount of your salary reduction may not exceed the lesser of your earned income or the earned income of your spouse. In addition, if your spouse is a full-time student or incapable of self-care (disabled), he or she is assumed to have income as follows:

- If you pay dependent care expenses for one dependent, you may assume that your spouse's income is $250 per month.

- If you pay dependent care expenses for two or more dependents, you may assume that your spouse's income is $500 per month.

- Your spouse's assumed income applies only to the months that he or she is a full-time student or disabled.

- If you are married and will file a joint return, the total amount that you and your spouse may contribute to this plan is $5,000, subject to the above earned income limits.

- If you are married and will file a separate return, but not as head of household, the maximum amount you may contribute to the plan is $2,500. Special rules apply to which spouse may claim dependent care expenses, so be sure to consult your tax advisor.

- If you or your spouse participates in any other dependent care plan during the same calendar year in which you participate in the City of Seattle Dependent Care Flexible Spending Account, the IRS limit is $5,000.00 for all plans combined.

- Further limitations may apply based on your income, your spouse's income, and your filing status. Refer to IRS Publication 503, Child, and Dependent Care Expenses.

Your annual salary reduction amount is divided into equal payroll deductions during the plan year. No deductions will be taken from the third paycheck of the month. These amounts are then deposited into your dependent care account.

The amount of salary reduction you elect should not exceed your estimate because federal tax regulations require you to forfeit any amount not expended for a plan year.

The following worksheet will help you estimate your eligible dependent care expenses:

Estimated Plan Year Expenses	
Babysitter	$
Day Care Center	$
Nursery School	$
After-School Care	$
Day Camp	$
Care for Qualifying Adult	$
Total Estimated Expenses	**$**

EFFECT ON OTHER BENEFITS

If you contribute to the Dependent Care FSA, your maximum allowed contribution to the City of Seattle Deferred Compensation Plan could be reduced to lower gross earning.

There is no effect on your other City benefits, such as life insurance or retirement.

MAKING CHANGES

The election you make when you enroll is effective for the entire plan year. You may only change your election – begin, increase, decrease or stop your contributions – during open enrollment, or when you have a qualifying status change. The following are examples of qualifying status changes:

- Change in your legal marital status including marriage, divorce, death of a spouse, legal separation or annulment
- Change in the number of your dependents due to birth, adoption or placement for adoption, or death of a dependent
- Ending or starting employment by you, your spouse or dependent, including a switch between part-time and full-time status, a strike, lockout or beginning or return from an unpaid leave of absence (including FMLA leave)
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan
- Change in the place of residence or work of you, your spouse or dependent
- Significant changes in day care provider's rates (except if relative).
- Change in day care situation that affects the rates (provider change, infant rate to toddler rate).

You have 31 days from the date of the event to change your FSA election(s). The change you make must be consistent with and on account of your status change. For example, if you adopt a child you can begin or increase contributions to a Health Care FSA (that is consistent with the status change), but you cannot stop or reduce contributions to a current FSA (that is not consistent). Questions? Please contact your department human resources representative.

REIMBURSEMENT

Copy and use the Dependent Care Reimbursement Request Form at the end of the plan booklet to get reimbursed for dependent care expenses or use the copy on the City Benefits web site at http://inweb/personnel/benefits

FILING A CLAIM

Claims for reimbursement from your spending account may be submitted any time during the plan year in which the expenses are incurred, but must be submitted before March 31st following the close of the plan year. With the claim form, you must submit a bill or receipt from the provider that gives the following information:

- Name and address of the provider and the provider's taxpayer identification number and signature
- The date(s) of services were provided
- The type of service provided
- Who received the service

When your Dependent Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to your account balance. If your request is greater than your current account balance, the remainder will be paid to you later, after additional contributions are made to your account.

NOTIFICATION OF CLAIM DENIAL

You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an additional 90 days. If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied.

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, a description of any additional information or material needed to complete your claim and an explanation of why the information is necessary and appropriate information about the plan's claims review procedures.

APPEALING A DENIED CLAIM

If your claim is denied and you wish to appeal, you must file your appeal with the Plan Administrator within 60 days after you receive the denial. Your appeal should include any additional information that you wish the Plan Administrator to consider. If your appeal is not filed within this 60-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. The decision will be final and binding on

all parties and will be communicated to you in writing. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

IF YOU LEAVE EMPLOYMENT

If you leave employment, you may continue submitting reimbursement requests for eligible expenses incurred through the end of the calendar year in which you terminated. You must submit all requests by March 31 of the following calendar year.

FSA FORMS

The following forms are included in this booklet.

- FSA Enrollment Form
- Health Care Reimbursement Request Form
- Dependent Care Reimbursement Form
- Authorization Agreement for Direct Deposit Request Form
- Change/Termination Form

CITY OF SEATTLE 2010 FLEXIBLE SPENDING ACCOUNT ENROLLMENT AND SALARY AGREEMENT FORM

Enrollment is easy on Employee Self-Service (ESS) at http://selfservice.ci.seattle.wa.us/. Online enrollment improves accuracy; your submission serves as your electronic signature. **Go to page 2 for ESS online instructions.**

Use this form only if you cannot access Employee Self-Service.

Last Name (Please Print) First Name _____ Employee No _____ Department _____ Bargaining Unit _____

Home Address - Street _____ City, State, Zip _____ Work Telephone _____

☐ **Health Care FSA**
Medical, Dental and Vision expenses not covered by your insurance plans

☐ **Dependent Care FSA**
Day Care expenses for eligible dependents

Health Care Flexible Spending Account Contribution Amount	**Dependent Care (Day Care) Flexible Spending Account Contribution Amount**
The minimum amount you can contribute is $25 each month. (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(The monthly amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.	The minimum amount you can contribute is $25 each month (*$25 x 12 = $300 per year.)* The maximum is $416.66 each month *($416.66 x 12 = $5,000 per year.)* I authorize the City to deduct $ _____ from my salary **each month** before federal taxes are withheld. **(The monthly amount cannot exceed $416.66.)** I understand that this amount cannot be revoked or modified during the plan year except as explained in the materials provided.
Deduction Schedule	**Deduction Schedule**
I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**	I understand that the City will deduct **half** of my contribution from the first paycheck and **half** from the second paycheck each month. **Note: NO deduction is taken from the third paycheck.**
For 2010, this is a ☐ new enrollment ☐ re-enrollment	For 2010, this is a ☐ new enrollment ☐ re-enrollment

Note: This paper (hard copy) form is not valid unless signed on the reverse side.

Signature

My signature below indicates that I have read the enrollment form and descriptive materials, including the plan document, covering the Health Care and/or Dependent Care Flexible Spending Account programs provided by the City of Seattle. This enrollment form is binding on me and cannot be revoked or modified (other than as explained in the materials provided). I also understand that my salary will be reduced by the amount I have elected, that salary deductions occur twice a month (with no FSA deductions from the third paycheck), and that any amount left in my FSA account after all 2010 claims have been paid will be forfeited.

I also understand that this arrangement for paying eligible expenses with nontaxable dollars is intended to meet Internal Revenue Service requirements for such arrangements. If tax laws change or if this arrangement is deemed not to satisfy the requirements, I understand that the tax advantages described may not be available. I acknowledge that the City of Seattle makes no guarantee concerning the availability of any tax advantage.

Participant's Signature _____ Date _____

Please forward the completed form to <u>Your Department's Benefits Representative.</u>

Online Enrollment Instructions

Log onto the InWeb

8. **Go to**: http://selfservice.ci.seattle.wa.us/.
9. **Select** Employee Self-Service/.
10. **Enter your employee number and password** (if you do not know your employee number, contact your HR rep. For a password reset contact DoIT or the appropriate department contact.)
11. **Select Open Enrollment** on the menu, left side of the screen, under FAMILY.
12. **Select Flexible Spending Account.** If this is your first time opening the benefits enrollment, review the agreement and select agree.
13. **Select Flexible Spending Account** (again).
    Step 1 - Select re-enroll *or* enroll.
    Step 2 - Enter *MONTHLY* amount.
    Step 3 - Save your changes.
14. **Select** Summary of Election to confirm your 2010 benefit elections.

Remember: <u>DO NOT</u> submit a paper copy if you enroll on line.

CITY OF SEATTLE

Request for Reimbursement
HEALTH CARE CLAIM FORM

Employee (Last Name, First Name, Middle Init.)

Social Security Number (Optional)

Address

City State Zip

Daytime Phone (very important)

❑ Check here if address change

Please be sure to staple documentation of services provided to the back of this claim form. Acceptable documentation is: 1) Explanation of Benefits (EOB) from the insurance company; 2) statement or bill from the health care provider that shows date of service and your financial responsibility; or 3) for contact lens supplies and co-payments only, a receipt.

To be eligible for reimbursement, a health care expense must be for you, your legal spouse, or dependent as defined by the IRS. Furthermore, the expense must be for services performed during the plan year; and not be covered by any other health insurance (i.e. an out-of-pocket expense).

INSTRUCTIONS

Fill in the information below for health care expenses incurred by you or your eligible dependent. Each expense item must be accompanied by a receipt or bill or copy of your receipt or bill stating the DATE OF SERVICE. *Do not attach receipts or bills, which do not identify your expense as a health care expense*. NOTE: Expenses covered under a medical, dental, vision or hearing plan must be submitted under that plan first. **ATTACH A COPY OF THE EXPLANATION OF BENEFITS YOU RECEIVED FROM THE INSURER OR A CO-PAY RECEIPT.** Please keep a copy for your records.

te Expense **Incurred**	**Name & Relationship of Person Incurring Expense**	**Description of Service/Expense**	**Name of Service Provider**	**Your Unreimbursed Expense**
				$
			TOTAL Medical Care Expense Claim:	**$**

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of this claim and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant _____ Date _____

SEND COMPLETED CLAIM FORM TO:

Benefit Administration Company
P.O. Box 550
Seattle, WA 98111-0550
(206) 625-1800 or (800) 967-3709

Email: flexcs@baclink.com

OR, FAX CLAIM FORM TO: (206) 682-8016 (FAX)

(Note: If faxing claim **do not** mail original.)

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION. A FEE MAY BE CHARGED FOR REQUESTED COPIES.

Health Care and Dependent Care Claim Form Instructions Bulletin

REQUEST FOR REIMBURSEMENT

Prompt claim processing is largely dependent on the submittal of a properly completed *Request for Reimbursement* form (Health Care -vs.- Dependent Care Reimbursement). A properly completed form includes:

- Legible personal information (employee name & current address)
- Employer Name (when not using a pre-printed form from your Employer)
- A marked change of address box, if applicable
- Legible claim description and expense information
- A legible, itemized statement and/or receipts from your provider
- An Explanation of Benefits (EOB) from all health insurance carriers
- Claim total
- Employee SIGNATURE
- A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check-printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

CHECK STOP PAYMENT and/or CHECK REISSUE REQUESTS

Benefit Administration Company (BAC) will process check stop payment and/or reissue according to the following guidelines:

- All stop payment requests will be held for a minimum waiting period of ten business days from the original check release date.
- Once BAC has placed the stop payment with the financial institution, the reissued check will be held for 2 business days in accordance with the financial institution's requirement.
- **A $30 processing fee will apply for all stop payment/reissued checks not resulting from a BAC error**
- BAC will issue a replacement check for a damaged original check only after the original check has been returned to BAC

OTHER HELPFUL HINTS

- Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts, and provider balance forward statements are not acceptable documentation.
- A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.
-

EXAMPLES OF EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Health Care Spending Account: weight loss programs unless prescribed to treat a specific medical condition, cosmetic surgery, teeth bleaching, missed appointment fees or custodial care (nursing home)
- Dependent Care Spending Account: overnight camp, diapers, late payment charges and care provided while you or your spouse are not working

CITY OF SEATTLE

Request for Reimbursement
DEPENDENT CARE

Please print or type.

Employee (Last Name, First Name, Middle Init.)

Social Security Number (Optional)

Address

Period in which care was provided:

City State Zip From To

Daytime Phone (very important)

$ **AMOUNT OF CLAIM**

Please have your provider sign below or staple a receipt or bill from the provider or other substantiation for the above period to the back of this claim. Please keep a copy for your records.

Names and age of Dependents for Whom Care was Provided

INFORMATION ABOUT THE PROVIDER OF CARE

Full Name of Provider

Relationship of Provider to Employee, if Any

Provider's Address

Provider's Tax ID (or Social Security Number)

Though you need not send it to us you should have a form W-10 completed b y this provider in your tax records. You will need it when completing form 2441 for your income tax filing.

City State Zip

CERTIFICATION BY THE PLAN PARTICIPANT

As to the Maximum Benefits: This reimbursement, together with all prior reimbursements in the current plan year, will not exceed the lesser of my own earned income, or the earned income of my spouse, or $5,000.00 during the current calendar year. (If my Spouse is a full-time student or is incapable of self-care, then my spouse will be considered to have earned $200.00 per month if one dependent is being cared for, or $400.00 per month if two or more dependents are being cared for.)
As to the Provider of Care: (1) Neither myself nor my spouse can claim a dependency exemption for the provider; and (2) If the provider is one of my children, then the child was at least age 19 at the time the care was provided.
As to Services Rendered Outside the Home: If care has been provided outside the home, then (1) The care was for a child under the age of 13; or (2) the care was for my physically or mentally incapacitated dependent or spouse who was unable to care for himself or herself. The dependent or spouse regularly spends a minimum of eight hours per day in my home.

Signature of Participant Date

RECEIPT: As an alternative to submitting a copy of your receipt for dependent care services, you may have the provider of care verify the performance of services by having them sign here.

Signature of Provider of Care Date

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION. A FEE MAY BE CHARGED FOR REQUESTED COPIES.

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION!
A FEE WILL BE CHARGED FOR ALL REQUESTED COPIES!

P.O. Box 550
Seattle, WA 98111-0550
(800) 967-3709
(206) 682-8016FAX
(Note: If faxing claim **do not** mail original.)
www.benefitadministrationcompany.com

Health Care and Dependent Care Claim Form Instructions Bulletin

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- ❑ Legible personal information (employee name & current address)
- ❑ Employer Name (when not using a pre-printed form from your Employer)
- ❑ A marked change of address box, if applicable
- ❑ Legible claim description and expense information
- ❑ A legible, itemized statement and/or receipts from your provider
- ❑ An Explanation of Benefits (EOB) from all health insurance carriers
- ❑ Claim total
- ❑ Employee SIGNATURE
- ❑ A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

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- ❑ **A $30 processing fee will apply for all stop payment/reissued checks not resulted from a BAC error**
- ❑ BAC will issue a replacement check for a damaged original check only after the original check has been returned to BAC

OTHER HELPFUL HINTS

- ♦ Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts and provider balance forward statements are not acceptable documentation.
- ♦ A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- ♦ Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- ♦ IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Health Care Spending Account: weight loss programs unless prescribed for a specific medical condition, cosmetic surgery, teeth bleaching, missed appointment fees or custodial care (nursing home)
- Dependent Care Spending Account: overnight camp, diapers, late payment charges and care provided while you or your spouse are not working

CITY OF SEATTLE

Authorization Agreement For Flexible Benefits Direct Deposits

I hereby authorize Benefit Administration Company to initiate deposit of my flexible benefits reimbursements to the bank account(s) indicated below and, if necessary, debit entries and adjustment for any credit entries made in error to my account(s).

(*You must attach a copy of a cancelled check to have reimbursement sent to your checking account.*)

This account is (Please check one of the following options)

New_____ Change_____ Cancel_____

_____	_____	_____
Transit ABA Routing Number	Account Number	Account Type (Checking or Savings)

Name of Bank:

_____

Bank Address:

_____

_____

Bank Phone Number: _____

Please Print Your Name: _____

Social Security Number: _____

_____	_____
Signature	Date

City of Seattle

Benefit Administration Company

FLEXIBLE SPENDING ACCOUNT CHANGE FORM

Employee

First Name	Last Name	Employee Number	Plan Year

EMPLOYEE ACTION – Type of Event/Contribution Election

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status events.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status event and that the change must be acceptable under the Regulations issued by the Department of Treasury and/or within 31 days (or 60 days for a new child) of that change.

The effective date for the change actions is the first of the month following the change, subject to payroll deadlines. My monthly contribution will appear on my earnings statement.

Life Status Change - Changes permissible due to these events must be on account of and correspond with the event. Check the reason you are completing the form on Page Two and enter the date of the event and your contribution amount.

Type of Action ☐ Enroll ☐ Change Contribution (increase or decrease) ☐ De-enroll

	Date of event	Current Payroll Contribution	New Payroll Contribution
Health Care	_____ (Mo/Day/Year)	$ _____ Yearly amount	_____ Yearly amount
Dependent Care	_____ (Mo/Day/Year)	$ _____ Yearly amount	_____ Yearly amount

The monthly contribution will be calculated by dividing the annual amount by the number of remaining pay periods in the year.

For Health FSA only – Approved Family Medical Leave (FML)

During my Family Medical Leave without pay:

☐ Cancel my coverage

☐ Continue my coverage. Upon my return, my monthly contribution will be the same as before the leave, except the annual amount will be reduced by the number of contributions missed while on leave.

☐ Continue my coverage. Upon my return, my annual contribution will be the same as before the leave, but I have make-up contributions to remain at the pre-existing level.

Signature

My signature indicates I have read and agree to the "Terms and Conditions" on this form. I certify under penalty of perjury that all of the above information is true to best of my knowledge and, if applicable, that I have experienced the event and/or cost change noted above.

Signature of Employee _____ Date _____

Continued on Page 2

Health FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry
☐ You marry and either – ▪ you and/or your dependent become eligible under and enroll in your new spouse's own employer's health plan, or ▪ your spouse is enrolled in his or her own employer's health FSA
☐ You lose your legal spouse through death, divorce, legal separation or annulment
☐ You lose your legal spouse through death, divorce, legal separation or annulment and you and/or your dependent lose coverage under your spouse's employer's health plan or health care FSA
GAIN OR LOSS OF A DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption or your eligible child moves in with you)
☐ You lose an eligible dependent or a dependent loses eligibility (for example, through death, or when an individual is no longer financially supported by you)
CHANGE IN EMPLOYMENT STATUS
☐ You, your spouse or dependent gains eligibility for and enrolls in own employer's health FSA, or enrolls self and you in own employer's health plan because you/he/she - ▪ starts employment or ▪ has an employment status change
☐ You, your spouse or dependent loses eligibility for own employer's health FSA or health care because you/he/she - ▪ ends employment, or ▪ has an employment status change

Services incurred prior to the change in status event can only be reimbursed to the maximum benefit in place on the date that the service was incurred. It is not available from the new election amount.

Dependant FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry and gain a dependent
☐ You marry and your spouse is either not employed, or is enrolled in his or her own employer's dependent care FSA
☐ You lose your spouse through death, divorce, legal separation or annulment and your spouse was enrolled in his or her own employer's dependent care FSA
GAIN OR LOSS OF DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption, or your spouse becomes incapable of self-care)
☐ You lose an eligible dependent (for example, through death, a child reaches age 25 or child is no longer a tax dependent)
CHANGE IN EMPLOYMENT STATUS
☐ Your spouse gains eligibility for and enrolls in own employer's dependent care FSA because he/she starts employment, or has an employment status change
☐ Your spouse loses eligibility in own employer's dependent care FSA because eh/she ends employment, or has an employment status change
COST CHANGE (DOES NOT APPLY IF PROVIDER IS YOUR RELATIVE BY BLOOD OR MARRIAGE)
☐ Your dependent care provider increase the cost of service
☐ There is a decrease in provider's cost
CHANGE IN PROVIDER OR COVERAGE
☐ You change dependent care providers
☐ Your spouse starts employment
☐ Your spouse ends employment
☐ There is a reduction in hours or cessation of dependent care (for example, a child starts attending school)
☐ You change (in whole or in part) from paid care to no care or free care (for example, free care by a neighbor, relative or for state-paid care
☐ You change (in whole or in part) from free/no care to paid care
☐ You or your spouse changes work schedules, which creates changes or eliminates need for dependent care
☐ Your spouse who is not employed or looking for employment becomes a full-time student, or becomes incapable of self care
☐ Your spouse who is not employed or looking for employment is no longer a full-time student, or is no longer incapable of self care

Please Forward this Form to the Human Resource Representative in <u>Your Department</u>

EMPLOYER USE ONLY COMPLETE BEFORE SENDING TO Benefit Administration Company

TERMINATIONS & LEAVES

Date of Termination/Leave _____ Last Pay Period Contribution Date _____

Date of Return to Work _____ First Contribution Date Upon Return _____

_____ _____

Employer Authorized Signature Total YTD Contribution